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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: December 7, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar magnetic resonance imaging (MRI) with and without contrast (72158).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)
☒ **Overturned (Disagree)**
☐ Partially Overturned (Agree in part/Disagree in part)

The requested lumbar magnetic resonance imaging (MRI) with and without contrast (72158) is medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on XX/XX/XX. The mechanism of injury was not documented. Past medical history was positive for hypertension, hyperlipidemia, asthma, cerebrovascular accident, and circulatory problems. Past surgical history was positive for multiple low back surgeries, including fusions from L4 to the sacrum. He underwent L2-3 and L3-4 decompression with coflex fusion at L2-3 and in-situ fusion at L3-4 on 11/26/13. Review of the progress reports from 12/10/13 to 5/1/15 revealed the patient to be doing well in the post-operative period with resolution of his lower extremity symptoms. He had residual back pain and had a hunched forward posture. He completed post-operative physical therapy with good functional gains and ability to walk greater than 500 yards. Oswestry Disability Index (ODI) scores indicated residual moderate functional loss. X-rays showed the coflex in appropriate position. Deep tendon reflexes were symmetric and hyporeflexic and sitting nerve root was negative. The 11/2/15 office visit indicated that the patient felt he still could not walk far and had to lean on a cart when shopping. He had pain with extension. Physical exam documented paraspinal tenderness, symmetrically absent reflexes, and negative sitting root test. X-rays

showed the coflex in good position. As he was continuing to complain of limited ambulation and back pain, magnetic resonance imaging (MRI) with gadolinium was recommended.
The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter 11/13/15 indicates that there is no documentation as to whether or not there has been a change in the physical examination. The URA further indicates that absent new symptoms or objective findings indicative of significant pathology, the request for a repeat MRI is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) recommend repeat lumbar spine magnetic resonance imaging (MRI) when there is a significant change in symptoms and/or findings suggestive of significant pathology. The ODG criteria have been met in this case. The patient presents with persistent and worsening back pain with difficulty walking and the need to lean on a cart when shopping. He is status post lumbar fusion surgery from L2-3 through L5-S1. The clinical examination findings now document absent lower extremity reflexes. Given the apparent significant change in symptoms, functional ability, and reflex change, the request for lumbar MRI with and without contrast is medically necessary at this time. In accordance with the above, I have determined that the requested lumbar MRI with and without contrast (72158) is medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**